IDAHO DEPARTMENT OF
HEALTH & WELFARE

JAMES E. RISCH – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

CERTIFIED MAIL: 7000 1670 0011 3314 8903

July 12, 2006

Gerald Bosen, Administrator
Weiser Rehabilitation & Care Center
331 East Park Street
Weiser, ID 83672

Provider #: 135010

Dear Mr. Bosen:

On **June 29, 2006**, a Recertification survey was conducted at Weiser Rehabilitation & Care Center by the Bureau of Facility Standards/Department of Health & Welfare to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. **This survey found the most serious deficiencies to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy, as evidenced by the attached CMS-2567 whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies/Plan of Correction, CMS Form 2567L, listing Medicare/Medicaid deficiencies, and a similar form listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **Please provide ONLY ONE completion date for each Federal/State Tag in column X5 (Complete Date), to signify when you allege that each tag will be back in compliance. NOTE: The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Date Certain" (listed on page 2). After each deficiency has been answered and dated, the administrator should sign both the CMS Form 2567L and State Statement of Deficiencies, in the spaces provided, and return the originals to this office.**

Your Plan of Correction (PoC) for the deficiencies must be submitted by **July 25, 2006**. Failure to submit an acceptable PoC by **July 25, 2006**, may result in the imposition of civil monetary penalties by **August 14, 2006**.

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
- Include dates when corrective action will be completed.

All references to federal regulatory requirements contained in this letter are found in *Title 42, Code of Federal Regulations*.

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS), if your facility has failed to achieve substantial compliance by **August 3, 2006 (Date Certain)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **August 3, 2006**. A change in the seriousness of the deficiencies on **August 3, 2006**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **August 3, 2006** includes the following:

Denial of payment for new admissions effective **September 29, 2006**. [42 CFR §488.417(a)]

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **December 29, 2006**, if substantial compliance is not achieved by that time.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact Loretta Todd, R.N. or Lorene Kayser, L.S.W., Q.M.R.P., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0036, Phone #: (208) 334-6626, Fax #: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **June 29, 2006** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

http://www.healthandwelfare.idaho.gov/_Rainbow/Documents/medical/2001_10.pdf
http://www.healthandwelfare.idaho.gov/_Rainbow/Documents/medical/2001_10_attach1.pdf

This request must be received by **July 25, 2006**. If your request for informal dispute resolution is received after **July 25, 2006**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact us at (208) 334-6626.

Sincerely,

Loretta Todd

LORETTA TODD, R.N.
Supervisor
Long Term Care

LT/dmj

Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135010	A. BUILDING _____ B. WING _____	06/29/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEISER REHAB & CARE CTR	331 E PARK ST WEISER, ID 83672

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following deficiencies were cited at the annual recertification survey at your facility. Surveyors conducting the annual survey were: Lorna Bouse, BSW, Team Coordinator Nicole Martin, RN Kim Heuman, RN Lea Stoltz, QMRP Survey Definitions: MDS = Minimum Data Set assessment RAP = Resident Assessment Protocol RAI = Resident Assessment Instrument DON = Director of Nursing LN = Licensed Nurse CNA = Certified Nurse Aide ADL = Activities of Daily Living MAR = Medication Administration Record	F 000	Changes to PoC made by phone conference call on 8/1/06 with administrator and DON. By: Lorna Bouse #FS - RECEIVED JUL 25 2006 FACILITY STANDARDS	
F 154 SS=D	483.10(b)(3), 483.10(d)(2) NOTICE OF RIGHTS AND SERVICES The resident has the right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. The resident has the right to be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility did not ensure a resident	F 154	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Weiser Rehabilitation & Care Center does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Gerald Boe	Executive Director	7-24-06

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 154	Continued From page 1 was fully informed of the potential risks and benefits associated with the refusal of receiving the pneumovax vaccination. This was true for 2 of 12 sampled residents (#3 and 4). The findings include: 1. Resident #3 was admitted to the facility on 11/1/01 and readmitted on 1/28/03 with diagnoses which included gastritis, history of breast cancer, depression and arthritis. Review of the resident's record revealed a "Condition Change Form" dated 4/15/06, which documented, "Review of res[ident] chart reveals no pneumovax given since admission [on]1/28/03. Will request [Dr's name] review clinic chart & [and] orders for pneumovax if indicated." A physician's telephone order dated 4/17/06 documented, "[No] pneumovax documented in clinic chart." A "Condition Change Form" dated 4/18/06 documented, "Res. states she has not had pneumonia, has not had the shot and does not want the shot." Further review of the resident's record, revealed no documentation indicating the facility had advised the resident of the potential risks and benefits of the pneumovax vaccine. On 6/28/06 at 1:15 pm, a LN was interviewed regarding the lack of documentation in the resident's record about informing the resident of the potential risks and benefits of the pneumovax. The LN stated the resident's record was reviewed and acknowledged no documentation could be	F 154	**Resident Specific** Resident # 3 & 4 continue to refuse the pneumovac. They and/or their responsible party are informed of the potential risks and benefits with evidence documented in the medical record. **Other Residents** The ID team will review all other residents who have refused the pneumovac and ensure risk and benefits have been explained and documented in the medical record. Further, the licensed nursing staff will receive in-service education related to informing the resident and/or responsible party of the risk and benefits of pneumovac refusals and provision of documentation within the medical record. By 8-3-06 **Facility Systems** Residents will be given pneumovac as per physician and infection control guidance. The licensed nurse will note all refusals with evidence of risk and benefit explanation placed in the medical record. **Monitor** The DNS and/or designee will review at least two residents weekly to ensure appropriate pneumovac documentation. Any concerns will be addressed immediately.	

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F 154	Continued From page 2 located stating the facility advised the resident of the risks and benefits of the vaccine. 2. Resident #4 was admitted to the facility on 3/7/06 and readmitted on 5/4/06 with diagnoses which included cancer, anemia and depression. Review of the resident's record revealed a "Physician's Orders" sheet dated 6/11/06 which documented, "3/7/06 pneumovax can be given if not already done." Further chart review showed no documentation of the pneumovax being given or refused. On 6/27/06 at 11:15 am, a LN was interviewed regarding the lack of documentation in the resident's record about informing the resident of the potential risks and benefits of the pneumovax. The LN stated resident #4 had refused the pneumovax when she spoke with him about it. The resident's record was reviewed and she acknowledged no documentation could be located stating the facility advised the resident of the risks and benefits of the vaccine.	F 154	The PI committee may adjust the frequency of monitoring, as it deems appropriate. **Date of Compliance** August 3, 2006	

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F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) STAFF TREATMENT OF RESIDENTS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced	F 225	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Weiser Rehabilitation & Care Center does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency. **Resident Specific** The ID team reviewed resident # 7 related to prevention of skin tears. The plan of care was updated as ~~indicated.~~ needed based on #7's assessment. **Other Residents** The ID team will review all other residents who have had unwitnessed skin tears to ensure investigation as to cause is identified and documented. This process will include, but not be limited to staff interviews and evaluation of environmental conditions. Further, the ID team and licensed nurses will receive in-service education related to obtaining adequate interviews, evaluation of	

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F 225	Continued From page 4 by: Based on record review, accident report review and staff interview, it was determined the facility failed to thoroughly investigate injuries of unknown origin to rule out neglect. This affected 1 of 12 sample residents (#7) evaluated for such injuries. Findings include: 1. Resident #7 was admitted to the facility on 9/5/02 with diagnoses that included Alzheimer's disease and diabetes. The current annual MDS, dated 4/14/06, documented the resident as severely cognitively impaired and in need of total assistance for all ADL cares. The resident's care plan, dated 4/28/06, identified problems for "Impaired physical mobility" and "Impaired skin integrity." Dated approaches included, "...Use mechanical lift for all transfers [6/5/06]...LN to trim nails every week on Saturday [4/8/04]...Resident to wear stockinettes or long sleeves on arms...[8/8/05]. Apply devices neuroflex splints to hands every am. CNA to remove after dinner [1/12/06]..." Facility "Event Reports" were reviewed for resident #7 and contained the following documentation: 1/20/06, (9:00 am)- "...Res[ident] has just been taken from the DR [dining room] to her room. CNA entered RM [room] and noted a 1 x 1 cm 3 corner skin tear on back of (R) [right] hand. Res was holding (L) [left] hand over her (R) hand & when CNA move[d] (L) hand she noted the skin tear...Res [with] HX [history] of fragile skin. Nails	F 225	environmental conditions, and documentation of findings. By 8-3-06. **Facility Systems** Residents with unwitnessed skin tears ,will be reviewed by the ID team the next business day. The team will document all interviews, environmental conditions, and investigative information noted during the review. **Monitor** The ED and/or designee will review all unwitnessed skin tears to ensure appropriate investigation and documentation. Any concerns will be addressed immediately. The PI committee may adjust the number of audits completed, as is deems appropriate. **Date of Compliance** August 3, 2006	

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F 225	Continued From page 5 [checked] & they are short. Res had (L) hand over (R) so possibly the skin tear happened when (L) hand was moved or even possibly @ [at] the breakfast table..." The aide who found the skin tear was interviewed. There was no indication that other staff were interviewed from the night shift who routinely got the resident up and dressed for breakfast. (See F241 for findings that related to night shift staff getting this resident up in the early morning). The investigation did not indicate if the aide that was interviewed also placed the resident at the dining room table or if other staff did. (The facility speculated that this could have been a point of injury for the resident). There was no indication if the resident had stockinettes or hand splints on during the meal. 3/6/06, (10:30 pm)- "...@ 2230 [10:30 pm] aide noted skin tear V shaped- .75 cm x 1.5 cm on back side of (lt) [left] hand. Area cleansed Bactroban applied [with] butterfly bandaides. Area was 2.5 cm diameter old bruise with dried blood...res had stockinette on hand/arms but does not cover upper hands- when res placed at table hands are folded in lap and in position for possible injury when placed up to the table- hands get rubbed on under side of table. Staff needs to raise table- check for clearance before putting res at table..." It was not evident that any staff were interviewed to determine if this was what really happened. This was an injury of unknown origin and the conclusion was reached because of the shape of the wound. "...location of bruise and direction of skin tear indicates that injury occurred when	F 225		

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F 225	Continued From page 6	F 225		

placed at table in DR. When hand moved back scraped on underside of table...Investigation revealed neuroflex splints probably protects hands during day. Will check height of table & investigate protective gloves for protection [after] splints come off."

3/15/06, [not timed]- "...3" [inch] long scrap[ed] bruise...CNA's were getting res. into mechanical lift sling- transfering [sic] her to w/c [wheel chair] for lunch. After getting her into w/c noted bruise scraped area on lf [left] f. arm [forearm]. Hand braces had come loose, there was no stockinette on her arms. Upon inspection of hand splint had a thick stiff area that could have scraped the area when moving her. It bleed a bit. Area cleaned...splint taken to O.T. to be covered [with] mole skin...CNA's & RNA's cautioned about making sure stockinette is on." It could not be determined if any staff were interviewed regarding this incident.

4/1/06, [8:00 pm]- "...res was up in w/c when pm staff came on- when [name of staff] put res to bed noted dry blood on sheep skin arm covers as well as fresh blood. Do not know how skin tears acquired- stockinettes on arms came midway up on forearms did not cover elbows...on right arm below elbow 2 V shaped skin tears 1.5 cm across- clear film applied - long stockinettes to cover entire arms..."

5/6/06, [1:40 pm]- "[No] skin tear when gotten [up], but found when put to bed...Skin tear noted to R[ight] arm. ..quarter size, approximated [with] drsg [dressing]...Unknown. Happened while res in w/c or during transfer [after] lunch...Event committee f/u [follow up]: ...O.T. [Occupational

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F 225	Continued From page 7 Therapy] placed in new w/c 3/06. Upon investigation [after] res up in w/c for lunch...with skin tear to (R) arm near elbow...stockinettes on & covering area..." There was no indication if her braces were on. 6/4/06, [1:40 pm]- "Upon raising res [with] mechanical lift dried blood was seen on res clothes which lead [sic] to discovery of skin tear. Night shift got res up before breakfast... found to have 1 cm x 1.5 cm skin tear to (R) elbow when laid down [after] lunch...assessment of cause: none found... The DON was interviewed on 6/29/06 at 8:30 am, regarding the repeated skin tear injuries of unknown origin for resident #7. The DON stated that staff were interviewed regarding the skin tears. This information was then reviewed by the event report committee and possible causes were discussed. However, this investigation was not documented. The resident was observed at 9:50 am, after the interview. She was in her room seated in her wheel chair. The activity director was putting lotion on her arms. The resident had stockinettes on and no braces. A CNA came in the room and was asked if she was assigned to care for the resident that day. She said she was. She was then asked why the resident did not have her braces on her hands. She stated the RNA usually put them on the resident. The CNA left the room. When observed at 11:00 am, the resident had her splints on. The facility did not provide evidence of thorough investigations for the injuries of unknown origin.	F 225		

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F 225	Continued From page 8 The reports did not indicate that all environmental conditions had been investigated to determine if the lift or wheel chair had areas which could cause injury when transferred. It was not evident that all possible staff who may have had insight or have witnessed the cause of the injuries were interviewed. The reports did not consistently indicate use of the braces which could have protected her hands.	F 225		
F 241 SS=E	483.15(a) DIGNITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and resident interviews, it was determined the facility did not ensure 4 of 12 sample residents (#'s 1, 2, 6 & 7), 2 random residents (#'s 15 and 16) and 1 unidentified resident were provided care which enhanced their dignity. Residents who were cognitively impaired were dressed at an inappropriate time of day, residents' private space was not respected, residents were not spoken to in a respectful manner by a LN, and residents were not assisted with activities of daily living to enhance their dignity. 1. Resident #7 was admitted to the facility on 9/5/02 with diagnoses that included Alzheimer's disease and diabetes.	F 241	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Weiser Rehabilitation & Care Center does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency. **Resident Specific** Upon notification of concerns, the DNS and ED completed rounds to ensure that dignity standards are met to include, but not limited to appropriate wake times established for cognitively impaired residents, appropriate	

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F 241	Continued From page 9 The current annual MDS, dated 4/14/06, documented the resident as severely cognitively impaired and in need of total assistance for all of her ADL care. Resident #7 was being dressed and receiving ADL by the night shift as evidenced by documentation in an event report and observations as follows: Event report, dated 6/4/06, documented, "...night shift got res[ident] up before breakfast..." (The night shift ends at 6:00 am). The resident was observed on 6/27/06 at 6:05 am. She was seated in her wheelchair next to the nurses' station in a small lounge area that led to the patio. She was fully dressed. At 7:00 am, the resident was observed to be seated in her wheelchair in the assisted dining room. From 7:00 am to 7:50 am, resident #7 sat unengaged in the dining room waiting for breakfast. Resident #7 was observed to be eating at 7:50 am, with total assistance from staff. She had been up for almost 2 hours. The resident who was assessed as being severely cognitively impaired was unable to communicate a choice to rise 2 hours before breakfast and remain unengaged during this period of time. 2. On 6/26/06 at 2:15 pm, the surveyor was standing by the nurses' station reviewing a resident record. Several (about 4) residents were seated in the lounge next to the nurses' station. There was a TV in the lounge but it was not on. One unidentified resident was seated in a recliner and asked the nurse at the nurses' station if the TV could be turned on. The nurse said, "Oh, do we have to listen to that today?" This was said in	F 241	tone of voice used with resident interaction, timely ADL assistance, door knock prior to entry to resident room, and window blinds closure for privacy during cares. Resident #'s 1, 2, 6, 7, 15 & 16. **Other Residents** The DNS and ED completed rounds as noted above for other residents. Further, staff will receive in-service education related to dignity standards to include, but not limited to appropriate wake times established for cognitively impaired residents, appropriate tone of voice used with resident interaction, timely ADL assistance, door knock prior to entry to resident room, and window blinds closure for privacy during cares. By 8/3/06. **Facility Systems** Staff receive orientation and training regarding dignity upon hire, annually, and as needed. Additionally, licensed nursing staff supervise direct acre staff to ensure compliance with dignity concerns including timely ADL assistance, door knocking prior to entry to resident room, and window blind closure for privacy during cares. Department managers to ensure all staff speak in an appropriate voice tone with residents throughout their interactions on rounds. The ID team will evaluate resident specific preferences for awakening in the morning	

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F 241	Continued From page 10 an impatient manner. The nurse did then pick up the remote and turn the TV on. 3. Resident #1 was admitted to the facility on 10/11/04 with diagnoses which included a history of Alzheimer's disease, chronic back pain and osteoporosis. Review of the resident's significant change MDS assessment, dated 5/19/06, indicated the resident was moderately impaired with cognitive skills for daily decision making, required extensive assistance from staff with transfer and one person assistance from staff with dressing, toileting and personal hygiene. On 6/28/06 at 8:45 am, resident #1 was observed seated in her wheelchair next to her bed wearing dress slacks and a pajama top. The room had a strong urine odor. The bottom sheet on the bed was visibly wet and a soiled incontinent brief and pajama bottom were on the floor at the foot of the bed next to the wheelchair. Resident #1's room was kept in line of sight for 20 minutes, and staff were not noted to enter her room between 8:45 and 9:05 a.m. At 9:00 am, resident #1 was noted to be sitting on the edge of the bed on the wet area of the sheet, having transferred herself. At 9:05 am, a CNA entered the room to assist resident #1 with the remainder of her dressing. Resident #1 was noted to be wearing the same slacks for the remainder of the day, that she had on when sitting on the wet sheet. Staff did not respond in a timely manner to resident #1's need for assistance with continent care and dressing. 4. Resident #2 was admitted to the facility on 2/15/05 with diagnoses which included a history of pneumonia, dehydration, hypothyroidism, reflux and seizure disorder.	F 241	and develop a plan of care to best accommodate them. Cognitively impaired resident will be allowed to awaken on their own unless otherwise indicated. **Monitor** The DNS and/or designee will round at least weekly to ensure resident dignity standards are met. Any concerns will be addressed immediately. The PI committee may adjust frequency of monitoring, as is deems appropriate. **Date of Compliance** August 3, 2006	

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F 241	Continued From page 11 Review of the resident's quarterly MDS assessment, dated 4/13/06, indicated the resident was moderately impaired with cognitive skills for daily decision making, required limited assistance from staff with transfer, extensive assistance from staff with dressing and limited assistance with toilet use. On 6/27/06 at 7:40 am, a CNA was observed to walk directly into the room without knocking on the door. The staff member was then observed to assist the resident with dressing. The staff member removed the resident's pajamas and assisted the resident with putting on his day clothes. During this observation, it was observed that the resident's window blinds were open to the outside. At that time, two individuals were observed to walk past the resident's window. 5. On 6/27/06 at 7:40 am, a CNA was observed to enter the room of random resident #s' 15 and 16. The staff member was observed to walk directly into the room without knocking on the door prior to entering. 6. Resident #6 was admitted to the facility on 7/30/01 with diagnoses which included Alzheimer's disease, renal lithiasis, chronic hematuria, and hyperlipidemia. Review of the resident's quarterly MDS assessment, dated 5/17/06, indicated the resident was severely impaired with cognitive skills for daily decision making and required total assistance with bed mobility, transfers, dressing and personal hygiene.	F 241		

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F 241	Continued From page 12 Review of the resident's comprehensive care plan, dated 5/18/06, revealed a problem of "Routine Care Needs r/t [related to] severe dementia, r/t dependent for cares" dated 1/14/03. The interventions, dated 1/14/03, documented, "Requires total care with dressing and grooming daily." On 6/26/06 at 11:25 am, 2 direct care staff were asked when resident #6 was gotten up in the morning. The staff members stated the night shift usually got the resident up between 5:30 am and 6:00 am. On 6/27/06 at 6:05 am, the resident was observed lying in bed asleep, a blanket covering the lower half of his body and dressed in a shirt that he was observed wearing the rest of the day.	F 241	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Weiser Rehabilitation & Care Center does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.	
F 248 SS=D	483.15(f)(1) ACTIVITIES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, it was determined that 1 of 12 sample residents (#7) reviewed for activities did not have planned activities designed to meet her needs in accordance with the comprehensive assessments related to her interests and physical conditions. Findings include:	F 248	**Resident Specific** A comprehensive ability focused activity assessment was completed for resident # 7 and a plan of care updated to meet her interests and physical/mental capabilities. **Other Residents** The activity staff will review all other residents over the course of the next quarter to ensure that a comprehensive ability focused assessment is completed to direct the plan of care for the residents based upon their interests and physical/mental capabilities. Further, the care staff will receive in-service education related to their role in providing	

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F 248	Continued From page 13 Resident #7 was admitted to the facility on 9/5/02 with diagnoses that included Alzheimer's disease and diabetes. The current annual MDS, dated 4/14/06, documented the resident as severely cognitively impaired and in need of total assistance for all ADL cares and was involved in activities less than 1/3 of the time. A RAP for activities triggered and included the following documentation: "Res is passive in activities, is on sensory stim. [stimulation], watch game show on TV turned on by staff. Husband here daily...proceed to care plan." The resident's care plan, dated 4/28/06, identified a problem for "Alteration in social/recreational therapy involvement R/T Alzheimers...Goal: Resident will passively attend music before meals...Approach: Tactile stimulation through in room activity: lotion/massage textured materials. Small group activity: seniorcize. Family participation in activities through: family visits, husband turns on tv to watch together. Based upon family/friends interview these are points for staff communication with resident: Previous employment: housewife. Previous hobbies: watches Price is Right on tv. items of enjoyment: pink. Ensure resident is aware of staff presence before proceeding with interactions. Approach slightly from the side, at eye level, in a calm manner." Activity flow sheets for May and June 2006 were reviewed. There were no activities documented for any of the four weekends in May. All activities were documented as passive. The resident had	F 248	pleasant and meaningful activities 7-days per week. By 8-3-06. **Facility Systems** The center will initiate a Resident comprehensive ability focused activity assessment that will direct individualized plans of care. Activity calendar and programming will be adapted to meet resident interests and physical/ mental capabilities 7-days per week. This will be completed for all residents by 8/3/06. **Monitor** The DNS and/or designee will review at least two residents weekly to ensure comprehensive ability focused activity assessments direct plans of care and are implemented. Any concerns will be addressed immediately. The PI committee may adjust the frequency of monitoring, as is deems appropriate. **Date of Compliance** August 3, 2006	

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F 248	Continued From page 14 lotion applied 21 days for the month of May. "Taste" was documented for the 19th and a barbecue on the 26th. (The resident had all pudding consistency foods as observed during meals on 6/26 at 12:15 pm and 6/27 at 8:00 am). It was documented the resident's spouse came in all days except weekends. (During the interview with the activity director on 6/29/06, she indicated the resident's spouse did come in on weekends). On one day (9th) she had talking books and on one day (11th) the resident had body/cologne spray. It was documented she listened to TV daily except weekends. (It could not be determined if that was with her spouse only, or if the facility provided it). "AM/PM Music" was documented daily except weekends for May 2006. Shaving the resident was documented as an activity for the 1st and 8th. (This was a hygiene activity and not part of what would normally be considered an activity of interest for most individuals). Similar documentation was for the month of June as the resident only received sensory stimulation in the form of touch (lotion), taste and smell four times. The resident was not observed to be a part of "Seniorcise" on any day of the survey from 6/26 through 6/30. This was documented as an activity provided weekdays (at 10:00 am) on the June 2006 activity calender. When the activity was observed on the 28th and 29th it was not a small group activity as stated in the care plan. There was quite a large attendance by residents who could participate in exercise. The resident was not observed to have a radio or other device to play music by her bedside. She was not observed during survey to have music playing in her room. There was a very small TV in her room. Her roommate was observed seated in a chair with	F 248		

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F 248	Continued From page 15	F 248		

the TV on, but resident #7 was only observed to be up in her wheel chair watching TV on 6/29/06 at 9:50 am. The activity director then came in, removed the resident's stockinettes, and applied lotion to her forearms and hands. This took less than 5 minutes.

The activity director was interviewed on 6/29/06 at 10:20 am. She stated the staff did try to make sure the resident could watch "The Price is Right." She stated the resident's family had indicated the resident liked to watch it every day. She stated the resident's spouse came in daily, including weekends, and watched a movie or TV with the resident. When asked about playing music for the resident, the activity director said, "Her roommate has a cassette player and when we play spiritual music for her [resident #7] can hear it." (None of the activity assessments or any progress notes from 8/4/03 to 4/20/06 indicated what kind of music the resident liked to listen to).

The facility did not provide resident #7 with activities that were based on an assessment of her needs. The resident was cognitively impaired and not able to communicate her needs or do anything physically for herself.

This is a repeat deficiency from the 5/12/05 recertification survey.

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F 253 SS=E	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview and family interview, it was determined the facility did not provide the necessary services to keep the interior free of pervasive odors on the 200 hall and in room #101. This was the case for 2 of 12 (#1 and 7) sampled residents and for all residents who used these areas of the facility. Findings include: 1. Pervasive odors of urine were noted in the small lounge area by the nurses' station and extending on down the hall from rooms 218 to 224. It was noted throughout the survey days of 6/26 - 6/28/06 that containers with canvas bottoms and plastic lids were kept in the hall area by room 220. These containers were used to dispose of soiled clothing and soiled incontinence products. The odors were noted on 6/27/06 at 8:00 am. There was a strong odor of urine in the 200 hall described above. While approaching resident #7's room (located on the 200 hall) the urine odor became exceptionally strong with an ammonia smell. The room was observed by the surveyor. The bedding was removed from resident #7's bed. The window was cracked to let air in. Next to the bed and on the floor, there was a thermal knit blanket on a pair of dark pink women's underwear. The urine smell was very strong in that area. By 10:00 am, the urine odors were still	F 253	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Weiser Rehabilitation & Care Center does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency. **Resident Specific** Resident #'s 1 & 7 had their room cleaned and found to be free of odor. The soiled linen bins were emptied and odors eliminated. **Other Residents** The ED and DNS rounded in the center to observe for linen handling practices and odors. Immediate action was taken as indicated. Additionally, housekeeping and direct care staff will receive in-service education related to maintaining a clean and sanitary environment. The training will	

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F 253	Continued From page 17 pervasive in that end of the 200 hall. On 6/29/06 at 8:30 am, the surveyor noticed the smell of urine at the nurses' station. The smell was strong along the entire length of the hall to room 224. At this time residents were still eating in the small assisted dining room which was directly across from the nurses' station. 2. Resident #1 was admitted to the facility on 10/11/04 with diagnoses which included a history of Alzheimer's disease, chronic back pain and osteoporosis. Review of the resident's significant change MDS assessment, dated 5/19/06, indicated the resident was moderately impaired with cognitive skills for daily decision making, required extensive assistance from staff with transfer and one person assistance from staff with dressing, toileting and personal hygiene. On 6/27/06, from 6:10 am - 10:10 am, resident #1 was observed 9 times. During this 4 hour period she was in bed, alternately awake and asleep. Throughout the observations there was a strong urine odor pervasive in the room.	F 253	include, but not be limited to linen handling and eliminating odors. **Facility Systems** General housekeeping services are provided daily in the resident rooms. When concerns are observed by direct care staff, they will be immediately addressed and reported to housekeeping if indicated. Soiled linen is to be bagged and tied prior to placement in the collection bins for prevention of odors. **Monitor** The ED and/or designee will round in the center at least weekly and observe for linen handling practices, odors, and compliance with housekeeping standards. Any concerns will be addressed immediately. The PI committee may adjust the frequency of the monitoring, as is deemed appropriate. **Date of Compliance** August 3, 2006	

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F 280 SS=D	483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure that comprehensive care plans were periodically reviewed and revised after each assessment regarding residents' refusals of care. This was true for 1 of 12 sampled residents (#2). 1. Resident #2 was admitted to the facility on 2/15/05 with diagnoses which included a history of pneumonia, dehydration, hypothyroidism, reflux and seizure disorder. Review of the resident's quarterly MDS assessment, dated 4/13/06, indicated the resident was moderately impaired with cognitive skills for	F 280	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Weiser Rehabilitation & Care Center does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency. **Resident Specific** The ID team reviewed resident # 2 related to refusal to eat and specific care plan interventions. The plan of care was updated as ~~indicated~~. need based on comprehensive assessment. **Other Residents** The ID will review all other residents that are refusing to eat to ensure the plan of care includes specific interventions to direct the care for staff. In-service education will be provided to direct care staff related resident refusals for meals and use of specific care plan interventions. By 8/3/06. **Facility Systems** Residents that are found to be refusing meals will be reviewed by the ID team to determine the root cause. Where indicated, strategies will be developed and	

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F 280	Continued From page 19 daily decision making and needed supervision from staff with eating. Review of the resident's record meal monitor flowsheets for the months of May and June 2006 revealed the resident refused the breakfast meal 15 days in May and 17 days in June; the lunch meal 6 days in May and 7 days in June; and the supper meal 7 days in May and 13 days in June. Review of the resident's plan of care, dated 4/14/06, documented a problem of "Thought Processes, Impaired r/t [related to] alzheimers dementia as evidenced by: resisting cares r/t depression." The interventions listed included, "Watch for signs and symptoms of depression: 1) not eating 2) staying in his room; Intervention for target behaviors of resisting cares: 1) Leave alone in safe area and return 10-15 min[utes] later; Encourage to make own decisions at his level of ability as much as possible..." The care plan also revealed a problem of "Nutrition Altered..." The care planned interventions, dated 6/12/06, documented, "No more room trays; will eat all meals in Willow Room to be assisted c [with] eating." No further documentation could be located in the resident's care plan regarding the resident's refusals of meals and how staff should respond and intervene. On 6/28/06 at 8:25 am, the DON was interviewed. The DON was asked if there was further documentation in the resident's care plan related to the resident's refusal to eat and the interventions staff should take. The DON reviewed the resident's care plan and acknowledged that there was no specific documentation in the resident's care plan	F 280	documented on the plan of care for intervention when residents refuse meals. **Monitor** The ED/DNS and/or designee will review at least two residents weekly related to meal intake. When refusals are noted, the care plan will be reviewed for specific interventions to address this concern. Any concerns will be addressed immediately and discussed with the PI committee as indicated. The PI committee may adjust the frequency of monitoring as deemed appropriate. **Date of Compliance** August 3, 2006	

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F 280	Continued From page 20 regarding the resident's refusal to eat and how staff should intervene.	F 280	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Weiser Rehabilitation & Care Center does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.	
F 281 SS=D	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations and record review, it was determined the facility did not follow accepted standards of nursing practice when 1 of 1 nurses signed, as given, a medication prior to a resident (random resident #17) receiving the medication and leaving 2 multidose medication containers unsupervised in a resident's room (random resident #17). Accepted standards of nursing practice were also not followed when it was observed that staff transferred 1 of 12 sampled residents (#2) without the use of a gait/transfer belt. The findings include: 1. On 6/27/06 at approximately 9:25 am, the LN passing medications on the 200 hall was observed to administer Flovent inhaler and artificial tear drops to random resident #17. The LN was observed to set the medications down by the sink in the resident's room, wash her hands and leave the resident's room without taking the medications out of the resident's room and properly securing them. The surveyor then followed the LN out of resident #17's room and into another resident's room to continue the medication pass. Approximately 5 minutes passed and the surveyor informed the LN about	F 281	**Resident Specific** There was no outcome to resident #'s 17 & 2 related to the medications being left on the sink as noted in the statement of deficiencies. However, not withstanding the aforementioned, the DNS counseled with the nurse and reviewed the proper standard for medication administration documentation and securing medications. The DNS also counseled with the C.N.A. related to proper transfers with a gait-belt. **Other Residents** DNS and designees rounded in the center and provided in-service training for LN staff regarding documentation of medication administration and securing medications. Additionally, in-service education was	

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F 281	Continued From page 21 the medications left in resident #17's room. The LN then returned to the resident #17's room and a CNA, who was in the room, handed the LN the medications. According to "Nursing Interventions & Clinical Skills, Second Edition, 2000," pages 408 and 423, medications are to be "kept locked when not attended." The documented rationale stated, "medications are safeguarded when locked in cabinet or cart." 2. On 6/26/06, resident #2 was observed being assisted by a CNA with toileting needs. The CNA was observed to transfer the resident from his bed to the wheelchair and to and from the wheelchair and the toilet without placing a gait belt around the resident prior to the transfer. Review of the resident's quarterly MDS assessment, dated 4/13/06, indicated the resident was moderately impaired with cognitive skills for daily decision making, required limited assistance from staff with transfer, extensive assistance from staff with dressing and limited assistance with toilet use. Review of the resident's quarterly "Nursing Assessment/Partial" dated 4/3/06, documented the resident was at moderate risk for falls with a score of 8. Review of the facility's "Gait (Transfer) Belt" procedure documented, "Gait belts are used with any resident requiring 'hands on' assistance for ambulations or transfers unless contraindicated..."	F 281	provided for direct care staff regarding use of the gait/transfer belts. **Facility Systems** LN staff receives orientation and training related to medication administration standards including documentation using the dot system for the MAR as well as ensuring medications are secured. Additionally, direct care staff receives orientation upon hire related to the gait-belt standards. Finally, competency is checked for nursing staff annually and as needed. **Monitor** The DNS and/or designee will observe medication administration weekly and at least one transfer weekly to ensure proper standards are followed. Any concerns will be addressed immediately and discussed with the PI committee as indicated. The PI committee may adjust the frequency of the monitoring as deemed appropriate. **Date of Compliance** August 3, 2006	

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F 281	Continued From page 22 According to "Fundamentals of Nursing, Fourth Edition, 1997," a transfer belt (gait belt) "reduces risk of injury" and "should be used with all clients who require moderate-to-maximal assistance or have risk of falling or injury." On 6/29/06 at 8:40 am, the DON was interviewed. The DON was informed of the observation regarding the CNA observed to not use a gait belt on resident #2 during a transfer. The DON stated staff were to use a gait belt for transfers when a resident requires such assistance. 3. On 4/16/97, informational letter #97-3 was sent to all Idaho Nursing Facilities by the Bureau of Facility Standards. The letter stated, "On December 31, 1996, we issued an informational letter regarding documentation of medication administration. Due to concerns expressed by the long term care industry...we are providing this additional clarification. This issue arose when the Board of Nursing received information that long term care facility staff were signing medications as given at the time of the medication preparation, not after the resident actually had taken the medication...the Board's expectation, and the accepted standard of practice, is that licensed nurses document those things they have done, not what they intend to do...There are an unlimited number of ways a facility could meet this practice standard. One option would be to simply document only after the medication has been given. A facility could also choose to continue documenting the medication pour, provided that an additional system is developed to also document that the medications were given as poured. This additional system could be quite simple. For example, a small check could be	F 281		

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F 281	Continued From page 23 made in the box at the time of the pour, and nurse's initials could be added after the medication was given." On 6/27/06 at 9:30 am, The LN passing medications on the 200 hall was observed preparing the following medications for administration to random resident #17: Albuterol 90 mcg ii [two] puffs twice a day. Prior to giving the medications, the LN signed the medication administration record and then gave the resident the medications.	F 281	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Weiser Rehabilitation & Care Center does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.	
F 323 SS=D	483.25(h)(1) ACCIDENTS The facility must ensure that the resident environment remains as free of accident hazards as is possible. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, it was determined the facility did not ensure residents were not exposed to toxic chemicals and unsecured medications. The hazards observed were related to 1 of 2 medication rooms located in the facility. This had the potential to affect 100% of residents who were cognitively impaired and mobile. The findings include: On 6/26/06 at 11:55 am, 12:15 am, 12:30 am, and on 6/27/06 at 7:10 am, the medication room on the 200 hall was observed unlocked and unsupervised. Located in the medication room was an unlocked refrigerator which contained multiple bottles of Milk of Magnesium, Aloe Vera	F 323	**Resident Specific** No outcome to any resident as noted in the statement of deficiency. The medication room on the 200 hall was secured immediately. **Other Residents** The DNS rounded in the center to ensure that the other medication rooms were secured and other potentially harmful chemicals and medications were secured. LN staff on the 200 hall received in-service education related to ensuring the medication room was secured when unsupervised. **Facility Systems** Medication rooms are locked when unsupervised so as to prevent risk to residents. LN staff is informed of this in general orientation. LN staff carry a key to allow easy access when necessary.	

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F 323	Continued From page 24 gel, and a vial of Tuberculin. Also located in the medication room were unlocked cabinets which contained a full container (128 fluid ounces) of peri-wash solution and 2 (16 fluid ounces) of Isopropyl Alcohol, both of which could be hazardous if ingested. On 6/27/06 at 12:15 pm, the facility was informed that the medication room was observed to be unlocked with potentially hazardous chemicals and medications inside.	F 323	**Monitor** The ED and/or designee will round in the center at least weekly to ensure mediation rooms are secured and no potentially harmful chemicals are available to cognitively impaired residents. Any concerns will be addressed immediately and discussed with the PI committee as indicated. The PI committee may adjust the frequency of monitoring as deemed appropriate. **Date of Compliance** August 3, 2006	
F 324 SS=D	483.25(h)(2) ACCIDENTS The facility must ensure that each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record review, review of incident and accident reports, and staff interview, it was determined the facility did not provide adequate assistive devices or staff supervision for 2 residents who experienced falls and skin tears. This was true for 2 of 12 (#1 and #7) sampled residents. The findings included: 1. Resident #1 was admitted to the facility on 10/11/04 with diagnoses which included a history of Alzheimer's disease, chronic back pain and osteoporosis. Review of the resident's significant change MDS assessment, dated 5/19/06, indicated the resident was moderately impaired with cognitive skills for	F 324	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Weiser Rehabilitation & Care Center does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.	

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F 324	Continued From page 25 daily decision making, required extensive assistance from staff with transfer and one person assistance from staff with dressing, toileting and personal hygiene. The 12/6/05 quarterly fall risk assessment indicated resident #1 was at minimum risk with a score of "5". The subsequent 3/2/06 quarterly fall risk assessment indicated she was at high risk with a score of "22". The 3/8/06 "Care Plan" listed as a problem, "At risk for falls Hx (history) of falls, unsteady gait, history of falls and use of psychotropic drugs." Under "Approach" on the care plan, the following interventions were listed: "...Monitor for effectiveness of psychotropic drugs, Keep adjustable bed in low position for safe transfers, Lock bed brakes, Pressure pad alarm to remind resident to use call light for assist and to alert staff of attempts to self transfer, Non-skid strips on floor in the bathroom, pressure pad alarm on when in W/C, Pressure pad alarm when in bed." The 6/1/06 "Care Plan" again listed as a problem, "At risk for falls Hx (history) of falls, unsteady gait, history of falls and use of psychotropic drugs." Under "Approach" on the care plan, the following interventions were listed: "...Monitor for effectiveness of psychotropic drugs, Keep adjustable bed in low position for safe transfers, Lock bed brakes, non-skid strips on floor next to bed, non-skid strips on floor in the bathroom, pressure pad alarm when in W/C, pressure pad alarm when in bed, aides to check pressure pad alarm at beginning of each shift to ensure correct placement and that the pad is attached to the alarm box."	F 324	**Resident Specific** The ID team reviewed resident #'s 1 & 7 related to prevention of falls and skin tears. Trends were reviewed and staff trained as indicated. The plans of care were updated as ~~indicated~~ needed per comprehensive assessment. **Other Residents** The ID team reviewed all other residents with falls and skin tears reviewing trends. In-service education will be provided to direct care staff regarding consistent care plan implementation and strategies to prevent falls and skin tears. By 8/3/06. **Facility Systems** Residents are assessed upon admission, quarterly and with any significant change of condition related to risks for falls and skin health. A plan of care is developed and documented as indicated. Direct care staff are informed of specific care plan interventions in order to implement consistently. LN staff supervise direct care staff daily to ensure consistent implementation. Injuries are thoroughly investigated and cause determined. Specific interventions are implemented based on the investigation and documented on the plan of care as indicated. **Monitor** The DNS and/or designee will review at least two residents weekly to ensure preventative measures on the care plan are	

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F 324	Continued From page 26 Review of the facility's "Incident Reports" showed resident #1 had sustained 7 falls since 1/06. According to the report dated 1/12/06, resident #1 was found seated on the floor in her room. When asked what happened, she said she lost her balance while putting clothes into the dresser drawer. The "Recommendations" for the incident were to evaluate her slippers, do a pain assessment and continue P.T. [physical therapy]. An "Incident Report" dated 1/15/06, indicated resident #1 had sustained a fall from her bed to the floor. She was found on the floor, reportedly having "slipped" out of bed when attempting to use the bathroom. The "Recommendations" for the incident were to do a pain assessment, place non-slip strips on the floor at the bedside, implement a motion alarm at all times. On 2/13/06 resident #1 fell during an independent transfer from the bed to her wheelchair. The brakes were not locked on the wheelchair. According to the report, she had removed the motion sensor and the pad alarm on the bed was not plugged in at the time. The "Recommendations" for the incident were to obtain self locking brakes for the wheelchair, place non-slip strips on the floor of the bathroom, implement a bed pad alarm and pressure pad alarm and inservice staff on the alarms. According to a 2/22/06 report, resident #1 was found on her back on the floor in her room. She had removed the motion sensor prior to the fall. The "Recommendations" for the incident were to obtain a diagnostic evaluation by the physician,	F 324	implemented consistently. Any concerns will be addressed immediately and discussed with the PI committee as indicated. The PI committee may adjust the frequency of monitoring as deemed appropriate. **Date of Compliance** August 3, 2006	

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conduct 15 minute checks until a chair pad was available and continue P.T.

Resident #1 sustained a fall on 3/31/06 during an independent transfer from her wheelchair to the bed. The pressure pad was reportedly in place but not attached to the alarm box. The "Recommendations" for the incident was to inservice staff to check alarms for functioning status at the beginning of shift, and to replace malfunctioning alarms with a functioning alarm.

On 6/21/06 resident #1 was found on the floor of the bathroom after attempting to transfer independently. The "Recommendations" for the incident was to educate staff to leave the bathroom door open (slightly) so staff could visualize the resident.

According to a 6/25/06 report, resident #1 was found sitting on the floor next to the empty bed in her room. She reportedly had gotten into the empty bed, fell asleep and woke up disoriented. The "Recommendations" for the incident were to inservice staff and to place a floor sensor alarm by the bed.

At 12:02 pm on 6/26/06, resident #1 was observed in her wheelchair in the lobby of the facility. An electrical cord was noted under the seat of her wheelchair, dragging on the floor. An empty fabric bag was hanging from the back of the wheelchair also. The LN was asked what the cord was. She reached into the bag and stated "The box isn't in there." She left and returned with a small plastic box which she attached to the cord and placed in the bag. The DON was present and stated resident #1 was "...supposed to be getting

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F 324	Continued From page 28 a pressure alarm mattress for her wheelchair." On 6/26/06 resident #1's care plan was revised to discontinue pressure pad alarms in wheelchair and bed. On 6/28/06 at 8:45 am, resident #1 was observed seated in her wheelchair next to her bed. She was also observed in the wheelchair at 8:55 am. At 9:00 am, resident #1 was noted to be sitting on the edge of the bed. A pad alarm was in place on the floor in front of her bed which, when checked, was found to be turned off. The DON was asked, on 6/29/06 at 10:05 a.m., about the interventions and corrective action to prevent resident #1's falls. She stated the team had determined that resident #1 fell transferring from wheelchair to bed, and the pressure pad alarms in the wheelchair and bed were being replaced by the floor sensor pad. She was informed at that time, that the alarm had not been turned on during the 6/28/06 observation, at which time resident #1 had transferred from the wheelchair to the bed independently. She stated staff had been inserviced on ensuring the pad alarm was on. When asked if any other interventions had been implemented to prevent resident #1 from continued falls, she stated no other measures had been taken. The facility did not supervise or provide adequate protective devices to prevent falls for resident #1. Devices to protect the resident were not correctly and consistently used. 2. Resident #7 was admitted to the facility on 9/5/02 with diagnoses that included Alzheimer's disease and diabetes.	F 324		

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F 324	Continued From page 29 The current annual MDS, dated 4/14/06, documented the resident as severely cognitively impaired and in need of total assistance for all of her ADL care. The resident's care plan, dated 4/28/06, identified problems for "Impaired physical mobility and for impaired skin integrity." Dated approaches included, "...Use mechanical lift for all transfers [6/5/06]...LN to trim nails every week on Saturday [4/8/04]...Resident to wear stockinettes or long sleeves on arms...[8/8/05]. Apply devices neuroflex splints to hands every am. CNA to remove after dinner [1/12/06]..." Facility "Event Reports" were reviewed for resident #7 and contained the following documentation: 1/20/06, (9:00 am)- "...Res[ident] has just been taken from the DR [dining room] to her room. CNA entered RM [room] and noted a 1 x 1 cm 3 corner skin tear on back of (R) [right] hand. Res was holding (L) [left] hand over her (R) hand & when CNA move (L) hand she noted the skin tear...Res [with] HX [history] of fragile skin. Nails [checked] & they are short. Res had (L) hand over (R) so possibly the skin tear happened when (L) hand was moved or even possibly @ [at] the breakfast table..." An inservice record was included in the report. The "lesson plan" was documented as, "Monitor res hands when up @ table & also if she is holding one hand over the other remove top hand gently R/T [related to] fragile skin.." 3/6/06, (10:30 pm)- "...@ 2230 [10:30 pm] aide	F 324		

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noted skin tear V shaped- .75 cm x 1.5 cm on back side of (lt) [left] hand. Area cleansed Bactroban applied [with] butterfly band aides. Area was 2.5 cm diameter old bruise with dried blood...res had stockinette on hand/arms but does not cover upper hands- when res placed at table hands are folded in lap and in position for possible injury when placed up to the table- hands get rubbed on under side of table. Staff needs to raise table- check for clearance before putting res at table...Will check height of table & investigate protective gloves for protection [after] splints come off." The gloves were not on the current care plan.

3/15/06, [not timed]- "...3 ' [inch] long scrap bruise...CNA's were getting res. into mechanical lift sling- transfering [sic] her to w/c [wheel chair] for lunch. After getting her into w/c noted bruise scraped area on lf [left] f. arm [forearm]. Hand braces had come loose, there was no stockinette on her arms. Upon inspection of hand splint had a thick stiff area that could have scraped the area when moving her. It bleed a bit. Area cleaned...splint taken to O.T. to be covered [with] mole skin...CNA's & RNA's cautioned about making sure stockinette is on." It could not be determined if any staff were interviewed regarding this incident. The staff were inserviced to make sure the stockinettes were on both arms at all times before splints were applied.

4/1/06, [8:00 pm]- "...res was up in w/c when pm staff came on- when [name of staff] put res to bed noted dry blood on sheep skin arm covers as well as fresh blood. Do not know how skin tears acquired- stockinettes on arms came midway up on forearms did not cover elbows...on right arm

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below elbow 2 V shaped skin tears 1.5 cm across- clear film applied - long stockinettes to cover entire arms..." Recommendations were to use longer stockinettes.

5/6/06, [1:40 pm]- "[No] skin tear when gotten [up], but found when put to bed...Skin tear noted to R[ight] arm. ..quarter size, approximated [with] drsg [dressing]...Unknown. Happened while res in w/c or during transfer [after] lunch...Event committee f/u [follow up]: ...O.T. [Occupational Therapy] placed in new w/c 3/06. Upon investigation [after] res up in w/c for lunch...with skin tear to (R) arm near elbow...stockinettes on & covering area..." There was no indication if her braces were on. Inserviced to place bolsters on both arms of the wheel chair.

6/4/06, [1:40 pm]- "Upon raising res [with] mechanical lift dried blood was seen on res clothes which lead [sic] to discovery of skin tear. Night shift got res up before breakfast... found to have 1 cm x 1.5 cm skin tear to (R) elbow when laid down [after] lunch...assessment of cause: none found... Recommendations: O.T. screen to pad area of concern on w/c..."

The DON was interviewed on 6/29/06 at 8:30 am regarding the repeated skin tear injuries of unknown origin for resident #7. The DON stated that the committee who reviewed the event reports discussed at length every possible scenario.

The resident was observed at 9:50 am, after the interview. She was in her room seated in her wheel chair. The activity director was putting lotion on her arms. The resident only had

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEISER REHAB & CARE CTR	331 E PARK ST WEISER, ID 83672

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 324	Continued From page 32 stockinettes on and no braces. A CNA came in the room and was asked if she was assigned to care for the resident that day. She said she was. She was then asked why the resident did not have her braces on her hands. She stated the RNA usually puts them on. The CNA left the room. When observed at 11:00 am, the resident had her splints on. In addition, the "stockinettes" were not the same as the traditional geri-gloves commonly used in long term care facilities. They were of a material that looked like a thin sock and stretched out easily. The area the thumb went through, was so stretched that the resident's hands were not covered by the fabric. The facility did not supervise or provide adequate protective devices to prevent skin tears for resident #7. Devices to protect the resident [stockinettes/braces] were not consistently used or used correctly. There was no indication that education to staff included proper transferring and use of the mechanical lift. The facility did not show evidence that they had attempted to identify staff who may have needed more training in these areas. This is a repeat deficiency from the 5/12/05 recertification survey.	F 324		

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F 328 SS=D	483.25(k) SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, it was determined the facility did not ensure that 1 of 3 sampled residents (#8) who received oxygen therapy was adequately monitored for titration of oxygen. The findings include: Resident #8 was admitted to the facility on 9/16/05 with diagnoses of congestive heart failure (CHF), chronic pulmonary obstructive disease (COPD), osteoporosis, hip fracture, dementia, depression and anxiety disorder. The resident was transported to a hospital emergency room on 9/18/05. The hospital discharge summary documented, "...This is a [age] year-old female, who transferred from the nursing home complaining of the patient just being very pale. O2 sats [oxygen saturation levels] down to 70%, apparently someone had neglected to keep her oxygen on. After evaluation in the Emergency Room, patient was found to be anemia [sic] and subsequently was admitted to	F 328	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Weiser Rehabilitation & Care Center does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency. The center strongly disagrees with the statement of deficiency as written. First, an order for Oxygen at a flow rate is continuous unless otherwise noted. Second, with an order for continuous Oxygen, initials on the MAR is sufficient to indicate administration by the LN. Finally, saturation levels would not be required unless the order specifically indicated a need to titrate to a specific range. A LN may use judgement to monitor saturation levels when respiratory distress is observed. However, notwithstanding the aforementioned, the center will continue to implement the following plan of correction as required. **Resident Specific** The ID team reviewed resident # 8 related to Oxygen therapy. Adjustments to the plan of care were made as deemed appropriate. **Other Residents**	

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F 328	Continued From page 34 the hospital..." The current physician's orders recapitulation (RECAP) for June 2006, documented an order for "O2 at 2 liters per nasal cannula for COPD." The order did not indicate if the O2 should be continuous or as needed. The resident was observed on 6/26/06 at 11:15 am laying on her back in bed. She had a specialized air exchange mattress on her bed. She was receiving a respiratory (Nebulizer) treatment via a mask. Later at 2:00 pm she was observed in her room asleep. She was receiving oxygen via nasal cannula at 3 liters per minute. On 6/27/06 at 6:55 am the resident was observed while receiving ADL care. She was receiving oxygen via nasal cannula at 2 1/2 liters per minute. When her oxygen was changed over from the bedside concentrator to the portable tank on her wheel chair the oxygen for the portable tank was set at 2 liters per minute. Resident #8's treatment records for the months of April and May 2006 documented initials only (each shift) that indicated staff had checked on the resident for use of her oxygen. There was no liter flow documented and no saturation levels documented. No initials were documented for at least one shift for 12 of 30 days in April and for 6 of 31 days in May. Nurse progress notes were not documented daily and contained only one note on 6/16/06 that stated, "O2 Sats 96%." There was no liter flow documented. The DON was interviewed on 6/29/06 at 8:30 am. She stated it was the standard to initial that the oxygen had been checked by nursing staff. She	F 328	The ID team will review all other residents receiving Oxygen therapy to ensure proper monitoring and documentation. Additionally, LN & direct care staff will receive in-service education related to ensuring proper Oxygen administration per physician order. By 8-3-06. **Facility Systems** Residents receiving Oxygen therapy have a proper physician order. If continuous, the LN will monitor at least every shift and document administration on the MAR with their initials. If concerns arise related to liter flows, the ID team will review and ensure a specific plan of care to ensure orders are followed appropriate. **Monitor** The DNS and/or designee will review at least one resident a week receiving Oxygen therapy to ensure an appropriate physician order and administration by LN staff. Any concerns will be addressed immediately and discussed with the PI committee as indicated. The PI committee may adjust the frequency of monitoring as deemed appropriate. **Date of Compliance** August 3, 2006	

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F 328	Continued From page 35 also stated that they did not check the resident's saturation levels more than one time a week. She stated she had checked the oxygen liter flow earlier that day for resident #8 and it was at 3 liters per minute. The DON stated the resident did not have a history of adjusting her liter flow rate independently. However, the DON felt it was possible the resident herself had changed the liter flow. The facility did not adequately monitor resident #8 for the use of her oxygen. Oxygen SATs in relation to liter flow were not being documented consistently. The resident was observed receiving oxygen at a liter flow above what the physician ordered. There were no notes to indicate this flow rate was adjusted by nursing staff due to symptoms which may have made it necessary.	F 328	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Weiser Rehabilitation & Care Center does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.	
F 514 SS=D	483.75(l)(1) CLINICAL RECORDS The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by:	F 514	**Resident Specific** The ID team reviewed resident #'s 1 & 2 related to meal intake documentation. Direct care staff received in-service education related to timely documentation on the provided flow sheets.	

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F 514	Continued From page 36 Based on observations, review of meal monitors, and staff interview, it was determined the facility did not ensure that meal monitors accurately reflected the amount of food consumed by residents. This was true for 2 of 12 (#1 & 2) sampled residents. The findings include: 1. Resident #1 was admitted to the facility on 10/11/04 with diagnoses which included a history of Alzheimer's disease, chronic back pain and osteoporosis. During the lunch meal observation on 6/26/06, resident #1 was noted to refuse all food and fluids offered. The resident's clinical record contained a "Meal Monitor Flow Sheet Record" on which staff were to document the percentage of each meal the resident consumed during each day for the months of May and June 1-25, 2006. The meal monitor for May 2006, indicated for 18 breakfast meals, 16 lunch meals and 14 dinner meals, the resident either refused the meal or ate 75% or less. However, the record did not indicate if the resident refused the meal replacement supplement or the amount of the supplement that was consumed if offered. For this month there were 43 meals where the space provided to document meal consumption was left blank. The form also indicated for staff to document the % [percentage] of intake of "mighty shakes tid [three times a day] with meals." There were 75 meals left blank. The meal monitor for June 2006, indicated for 10 breakfast meals, 12 lunch meals and 9 dinner	F 514	**Other Residents** The ID team reviewed meal intake flow sheets for all other residents. As noted above, direct care staff received in-service education related to timely recording of intake percentages on the flow sheets provided. 8-3-06 **Facility Systems** Direct care staff monitor meal intake and record a percentage of intake for each meal. When a resident refuses or does not otherwise eat their provided meal, a nutritionally comparative alternate is provided. The intake percentage recorded indicates the approximate amount of the meal consumed (original or alternative). When indicated by assessment, a supplement may be provided. If determined appropriate by the ID team, the percentage of the supplement will be monitored and recorded by direct care staff on the flow sheet. When a resident refuses meals frequently, direct care staff will report this to the ID team for further review. **Monitor** The DNS and/or designee will review at least two residents weekly related to appropriate recording of meal intake and supplement if indicated. Any concerns will be addressed immediately and discussed with the PI committee as indicated. The PI committee may adjust the frequency of the monitoring as deemed appropriate.	

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F 514	Continued From page 37 meals, the resident either refused the meal or ate 75% or less. However, the record did not indicate if the resident refused the meal replacement supplement or the amount of the supplement that was consumed if offered. For this month there were 44 meals where the space provided to document meal consumption was left blank. The form also indicated for staff to document the % of intake of "mighty shakes tid [three times a day] with meals." There were 64 meals left blank. On 6/28/06 at 10:15 am, the DON was interviewed regarding the facility's expectations regarding documentation on meal monitors. The DON stated staff were expected to document the consumption and supplement information on the flow sheets. 2. Resident #2 was admitted to the facility on 2/15/05 with diagnoses which included a history of pneumonia, dehydration, hypothyroidism, reflux and seizure disorder. The resident's clinical record contained a "Meal Monitor Flow Sheet Record" on which staff were to document the percentage of each meal the resident consumed during each day for the months of May and June 2006. The meal monitor for May 2006, indicated for 13 breakfast meals, 12 lunch meals and 4 dinner meals, the resident either refused the meal or ate 75% or less. However, the record did not indicate if the resident refused the meal replacement supplement or the amount of the supplement that was consumed if offered. For this month there were 7 meals where the space provided to document meal consumption was left blank. The form also indicated for staff to document the % of	F 514	**Date of Compliance** August 3, 2006	

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F 514	Continued From page 38 intake of "mighty shakes tid [three times a day] with meals." There were 15 meals left blank. The meal monitor for June 2006, indicated for 16 breakfast meals, 13 lunch meals and 2 dinner meals, the resident either refused the meal or ate 75% or less. However, the record did not indicate if the resident refused the meal replacement supplement or the amount of the supplement that was consumed if offered. For this month there were 10 meals where the space provided to document meal consumption was left blank. On 6/27/06 at 10:15 am, the DON was interviewed regarding the facility's expectations regarding documentation on meal monitors. The DON stated if a resident refuses to eat, staff are to offer shakes and alternates and document the amount taken.	F 514		

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C 000	INITIAL COMMENTS The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2. The following deficiencies were cited during the annual State licensure survey of your facility. The surveyors conducting the survey were: Lorna Bouse, BSW, Team Coordinator Nicole Martin, RN Kim Heuman, RN Lea Stoltz, QMRP Survey Definitions: MDS = Minimum Data Set assessment RAP = Resident Assessment Protocol RAI = Resident Assessment Instrument DON = Director of Nursing LN = Licensed Nurse CNA = Certified Nurse Aide ADL = Activities of Daily Living MAR = Medication Administration Record	C 000	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Weiser Rehabilitation & Care Center does not admit that the deficiencies listed on the State Form exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency. RECEIVED JUL 25 2006 FACILITY STANDARDS	
C 119	02.100,03,c,iii iii. Is fully informed, by a physician, of his medical condition unless medically contraindicated (as documented, by a physician, in his medical record), and is afforded the opportunity to participate in the planning of his medical treatment and to refuse to participate in experimental research; This Rule is not met as evidenced by: Refer to F154 as it related to the failure of the facility to fully inform residents of the risks and	C 119	Refer to the plan of correction for F 154	

Bureau of Facility Standards

Gerald Boe — TITLE: Executive Director — (X6) DATE: 7-24-06

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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C 119	Continued From page 1 benefits of the influenza and pneumococcal vaccine.	C 119		
C 125	02.100,03,c,ix ix. Is treated with consideration, respect and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; This Rule is not met as evidenced by: Please refer to F-241 as it refers to the facility's failure to ensure residents were treated with dignity and respect.	C 125	Refer to the plan of correction at F 241	
C 175	02.100,12,f f. Immediate investigation of the cause of the incident or accident shall be instituted by the facility administrator and any corrective measures indicated shall be adopted. This Rule is not met as evidenced by: Refer to F225 as it relates to the facility's failure to fully investigate injuries of unknown origin.	C 175	Refer to the plan of correction at F 225	
C 342	02.108,04,b,ii ii. All toxic chemicals shall be properly labeled and stored under lock and key. This Rule is not met as evidenced by: Please refer to F323 as it related to the facility's failure to ensure residents were not exposed to toxic chemicals and unsecured medications.	C 342	Refer to the plan of correction at F 323	
C 361	02.108,07 HOUSEKEEPING SERVICES AND EQUIPMENT	C 361		

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C 361	Continued From page 2 07. Housekeeping Services and Equipment. Sufficient housekeeping and maintenance personnel and equipment shall be provided to maintain the interior and exterior of the facility in a safe, clean, orderly and attractive manner. This Rule is not met as evidenced by: Please refer to F253 as it relates to the facility's failure to keep the interior of the facility free of pervasive odors.	C 361	Refer to the plan of correction at F 253	
C 674	02.151,01 ACTIVITIES PROGRAM 151. ACTIVITIES PROGRAM. 01. Organized Program. There shall be an organized and supervised activity program appropriate to the needs and interests of each patient/resident. The program shall be designed to include a variety of processes and services which are designed to stimulate patients/residents to greater self-sufficiency, resumption of normal activities and maintenance of an optimal level of psychosocial functioning. It shall include recreation, therapeutic, leisure and religious activities. This Rule is not met as evidenced by: Please refer to F-248 as it relates to the facility's failure to ensure the activity program met the needs of all residents.	C 674	Refer to the plan of correction at F 248	
C 745	02.200,01,c c. Developing and/or maintaining	C 745		

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C 745	Continued From page 3 goals and objectives of nursing service, standards of nursing practice, and nursing policy and procedures manuals; This Rule is not met as evidenced by: Please refer to F281 as it related to the facility's failure to follow accepted standards of nursing practice as it relates to medication administration and assistance with tranfers.	C 745	Refer to the plan of correction at F 281	
C 782	02.200,03,a,iv iv. Reviewed and revised as needed to reflect the current needs of patients/residents and current goals to be accomplished; This Rule is not met as evidenced by: Refer to F280 as it related to care plans not being reviewed and revised as needed.	C 782	Refer to the plan of correction at F 280	
C 788	02.200,03,b,iv iv. Delivery of medications, diet and treatments as ordered by the attending physician, dentist or nurse practitioner; This Rule is not met as evidenced by: Please refer to F328 as it related to the facility's failure to ensure that residents receiving oxygen therapy were adequately monitored for titration of oxygen.	C 788	Refer to the plan of correction at F 328	
C 790	02.200,03,b,vi vi. Protection from accident or injury; This Rule is not met as evidenced by: Refer to F324 as it relates to the facility's failure to protect residents from accidents and injury.	C 790	Refer to the plan of correction at F 324	

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C 881	02.203,02 INDIVIDUAL MEDICAL RECORD 02. Individual Medical Record. An individual medical record shall be maintained for each admission with all entries kept current, dated and signed. All records shall be either typewritten or recorded legibly in ink, and shall contain the following: This Rule is not met as evidenced by: Refer to F514 as it related to the facility maintaining clinical records on each resident that are complete and accurate.	C 881	Refer to the plan of correction at F 514	